FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004721

Facility Name: GENESEO GOOD SAMARITAN VILLAGE

Address: 704 S ILLINOIS ST (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (309) 944-6424 **Fax #** (309) 944-6605

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners: 1/1/1970

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605) 362-3843

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ELOYE FARRELL
(Title) ASSISTANT SECRETARY

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,159	15,993	715	25,867	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,159	15,993	715	25,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.43%

D. How many bed-hold days during this year were paid by Public Aid?
17 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	174,986	14,548	5,357	194,891		194,891		194,891			1
2	Food Purchase		130,630		130,630		130,630	(1,043)	129,587			2
3	Housekeeping	82,188	19,574		101,762		101,762		101,762			3
4	Laundry	65,433	9,703		75,136		75,136		75,136			4
5	Heat and Other Utilities			74,661	74,661		74,661	(510)	74,151			5
6	Maintenance	77,944	9,016	57,303	144,263		144,263	763	145,026			6
7	Other (specify):*			7,403	7,403		7,403		7,403			7
8	**TOTAL General Services**	400,551	183,471	144,724	728,746		728,746	(790)	727,956			8
	B. Health Care and Programs											
9	Medical Director			1,700	1,700		1,700		1,700			9
10	Nursing and Medical Records	1,157,164	75,616	1,413	1,234,193		1,234,193	(21,020)	1,213,173			10
10a	Therapy	10,931	686	37,116	48,733		48,733	(12,147)	36,586			10a
11	Activities	60,695	9,802	5,835	76,332		76,332	(120)	76,212			11
12	Social Services	41,164	18	1,113	42,295		42,295		42,295			12
13	Nurse Aide Training											13
14	Program Transportation			2,027	2,027		2,027		2,027			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,269,954	86,122	49,204	1,405,280		1,405,280	(33,287)	1,371,993			16
	C. General Administration											
17	Administrative	41,913		122,267	164,180		164,180	24,560	188,740			17
18	Directors Fees											18
19	Professional Services			5,480	5,480		5,480		5,480			19
20	Dues, Fees, Subscriptions & Promotions			25,645	25,645		25,645	(19,037)	6,608			20
21	Clerical & General Office Expenses	73,903	20,932	30,541	125,376		125,376	(30,107)	95,269			21
22	Employee Benefits & Payroll Taxes			371,246	371,246		371,246	(9,918)	361,328			22
23	Inservice Training & Education			21,690	21,690		21,690	(1,518)	20,172			23
24	Travel and Seminar			5,240	5,240		5,240	(673)	4,567			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,043	48,043		48,043	(11,480)	36,563			26
27	Other (specify):* Marketing & Res Dev	14,358		19,743	34,101		34,101	(14,358)	19,743			27
28	**TOTAL General Administration**	130,174	20,932	649,895	801,001		801,001	(62,531)	738,470			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,800,679	290,525	843,823	2,935,027		2,935,027	(96,608)	2,838,419			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE #0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			171,397	171,397		171,397	(10,556)	160,841			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			(80)	(80)		(80)	80				34
35	Rent-Equipment & Vehicles			3,948	3,948		3,948		3,948			35
36	Other (specify):*											36
37	**TOTAL Ownership**			175,265	175,265		175,265	(10,476)	164,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,501	39,501		39,501		39,501			42
43	Other (specify):*			542	542		542	(542)				43
44	**TOTAL Special Cost Centers**			40,043	40,043		40,043	(542)	39,501			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,800,679	290,525	1,059,131	3,150,335		3,150,335	(107,626)	3,042,709			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,043)	2		4
5	Telephone, TV & Radio in Resident Rooms	(510)	5		5
6	Rented Facility Space	80	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,815)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,038)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(90,672)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,998)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,372		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,372		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,626)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GENESEO GOOD SAMARITAN VILLAGE

ID# 0004721

Report Period Beginning: 1/1/03

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Administration	$ (35)	21	1
2	Activity	(120)	11	2
3	Postage	(68)	21	3
4	Uniform Income	(1,079)	21	4
5	Glucose Strip Exp	(6,793)	10	5
6	Deferred Maint Costs - 2000/2001	1,117	6	6
7	Depreciation Exp - Apt and Duplex	(9,009)	30	7
8	Deferred Maint Costs - 1996-1999	1,553	6	8
9	Depreciation Exp - Admin House	(1,547)	30	9
10	ProClaim Offset	(3,121)	10	10
11	Prescr Drugs - Reimb	(11,106)	10	11
12	Salaries - Res Dev	(9,324)	27	12
13	Vac Acc - Res Dev	(141)	27	13
14	FICA - Res Dev	(2,210)	22	14
15	Supplies - Res Dev	(3,118)	21	15
16	Sm Equip - Res Dev	(514)	21	16
17	Staff Dev - Res Dev	(1,518)	23	17
18	Salaries - Marketing	(4,893)	27	18
19	P/Serv-Laboratory-MDCR	(542)	43	19
20	Therapy Offset - PT, OT, ST	(12,147)	10a	20
21	Equipment Repair - Res Dev	(92)	6	21
22	Misc Fdraisers Exp	(19,742)	27	22
23	Newsletters - Res Dev			23
24	Staff Pension - Res Dev			24
25	Travel - Res Dev	(673)	24	25
26				26
27				27
28	Penalty Fees	(5,550)	21	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(90,672)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,043)	0	0	0	0	0	0	0	0	0	0	(1,043)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(510)	0	0	0	0	0	0	0	0	0	0	(510)	5
6	Maintenance	763	0	0	0	0	0	0	0	0	0	0	763	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(790)	0	0	0	0	0	0	0	0	0	0	(790)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(21,020)	0	0	0	0	0	0	0	0	0	0	(21,020)	10
10a	Therapy	(12,147)	0	0	0	0	0	0	0	0	0	0	(12,147)	10a
11	Activities	(120)	0	0	0	0	0	0	0	0	0	0	(120)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(33,287)	0	0	0	0	0	0	0	0	0	0	(33,287)	16
	C. General Administration													
17	Administrative	0	24,560	0	0	0	0	0	0	0	0	0	24,560	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(19,038)	0	0	0	0	0	0	0	0	0	0	(19,038)	20
21	Clerical & General Office Expenses	(10,364)	0	0	0	0	0	0	0	0	0	0	(10,364)	21
22	Employee Benefits & Payroll Taxes	(2,210)	(7,708)	0	0	0	0	0	0	0	0	0	(9,918)	22
23	Inservice Training & Education	(1,518)	0	0	0	0	0	0	0	0	0	0	(1,518)	23
24	Travel and Seminar	(673)	0	0	0	0	0	0	0	0	0	0	(673)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(11,480)	0	0	0	0	0	0	0	0	0	(11,480)	26
27	Other (specify):*	(34,100)	0	0	0	0	0	0	0	0	0	0	(34,100)	27
28	**TOTAL General Administration**	(67,903)	5,372	0	0	0	0	0	0	0	0	0	(62,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,980)	5,372	0	0	0	0	0	0	0	0	0	(96,608)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,556)	0	0	0	0	0	0	0	0	0	0	(10,556)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	80	0	0	0	0	0	0	0	0	0	0	80	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,476)	0	0	0	0	0	0	0	0	0	0	(10,476)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(542)	0	0	0	0	0	0	0	0	0	0	(542)	43
44	**TOTAL Special Cost Centers**	(542)	0	0	0	0	0	0	0	0	0	0	(542)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,998)	5,372	0	0	0	0	0	0	0	0	0	(107,626)	45

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin Acctg	$ 122,267		100.00%	$ 146,827	$ 24,560	1
2	V	22	Workers Comp	53,643			47,764	(5,879)	2
3	V	22	Unemploy Charges Paid	(51)				51	3
4	V	26	Insurance	48,042			36,562	(11,480)	4
5	V	22	Group Health Ins	137,212			135,332	(1,880)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 361,113			$ 366,485	$ * 5,372	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAG # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The EV Lutheran Good Samaritan Society
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 5117-5038
Phone Number: (605) 362-3100
Fax Number: (605) 362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See under separate cover the				$	$		$	1
2		Report on Allowable Central				NO ALLOCATION NECESSARY				2
3		Office Expenses for the Year								3
4		ended December 31, 2003								4
5										5
6		* The allocated expenses in this report related direclty to each centers								6
7		Nursing home facility and no additional re-allocation of these expenses								7
8		between healthcare facilities and non healthcare facilities/apartments								8
9		should be ncessary								9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	7,296	8
	1999	4,066	9
	2000		10
	2001		11
	2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENESEO GOOD SAMARITAN VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 8 UNITS
DUPLEXES - 21 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1969	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1971	1971	$ 494,740	$ 12,369	40	$ 12,369	$	$ 405,065	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING										9
10				1977	1,100		VARIES			1,100	10
11				1978	7,629		20			7,629	11
12				1981	168,876	5,451	VARIES	5,451		127,990	12
13				1982	2,299		VARIES			2,299	13
14				1986	2,926	15	VARIES	15	0	2,896	14
15				1987	15,313	520	VARIES	520		13,492	15
16				1988	124,091	5,306	VARIES	5,306		99,670	16
17				1989	32,054	978	VARIES	978		29,336	17
18				1990	108,416	5,423	VARIES	5,423		73,279	18
19				1991	3,157	53	VARIES	53		3,019	19
20				1992	36,755	1,204	VARIES	1,204		28,969	20
21				1993	75,750	4,242	VARIES	4,242		49,214	21
22				1994	69,096	4,490	VARIES	4,490		44,810	22
23				1995	76,363	4,713	VARIES	4,713		40,630	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING CONTINUED		$	$		$	$	$	37
38	CERAMIC FLOORING/BATHROOM QA-M	1996	107	5	20	5		43	38
39	LAUNDRY WALL PROTECTION	1996	1,109					1,109	39
40	ACTIVITY ROOM REMODEL/SINK	1996	2,132					2,132	40
41	LAUNDRY DOORS Q/A	1996	1,874	125	15	125		978	41
42	BATHROOM SINK	1996	678	34	20	34		268	42
43	AWNING FOR REHAB CLINIC	1996	983	98	10	98		762	43
44	NURSE CALL SYSTEM-DUPLEX	1996		58	10	58			44
45	KEMLITE IN CLOSETS	1996	653	65	10	65		501	45
46	POWER ACCESS DOOR OPERATOR	1996	1,009	101	10	101		774	46
47	GENERATOR/MOVE TO GSS	1996	3,431	343	10	343		2,630	47
48	CARPET FOR PARLOR	1996	2,627		5			2,499	48
49	A/C-ROOF TOP ON 200 WING	1996	229	15	15	15		115	49
50	ELECTRIC-REMODEL PARLOR	1996	186	9	20	9		70	50
51	BUILDING-REMODEL PARLOR	1996	1,132	57	20	57		424	51
52	PLUMBING-REMODEL PARLOR	1996	599	30	20	30		225	52
53	WALLPAPER-REMODEL PARLOR	1996	2,645		5			2,517	53
54	SHOWER REMODEL-GRAB BARS	1996	1,321	132	10	132		958	54
55	REPLACE FIXTURES/FLOOR/WALL	1996	3,955	198	20	198		1,417	55
56	WINDOWS	1996	25,212	1,681	15	1,681		12,046	56
57	BUILDING-REMODEL	1996	1,692	85	20	85		628	57
58	WINDOW FOR DINING ROOM	1997	1,650	110	15	110		761	58
59	300 WING CEILING TILE WORK	1997	2,584		5			2,584	59
60	WALL BUILT IN LAUNDRY ROOM	1997	1,013	101	10	101		701	60
61	WINDOWS	1997	5,100	340	15	340		2,352	61
62	WALLPAPER FOR JACK ANDREWS	1997	2,221		5			2,221	62
63	CARPET FOR CONFERENCE ROOM	1997	2,192		5			2,192	63
64	CONFERENCE ROOM WORK	1997	1,350	135	10	135		934	64
65	WALL PROTECTION	1997	739		5			739	65
66	NEW SPRINKLERS FOR OFFICE	1997	909	91	10	91		606	66
67	WALLPAPER-RESIDENT ROOM 308	1997	2,667 #		5			2,667	67
68	CARPET FOR RESIDENT ROOM	1997	506		5			506	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,291,070	$ 48,577		$ 48,577	$ 0	$ 975,757	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,291,070	$ 48,577		$ 48,577	$ 0	$ 975,757	1
2	BUIDLING CONTINUED								2
3	ENVIRONMENTAL ASSESSMENT OF 61	1997		130	10	130			3
4	ROOF-FRONT ENTRY	1997	21,178	1,059	20	1,059		7,324	4
5	SOCIAL SERVICE & CONFERENCE TOOM	1997	1,392	93	15	93		603	5
6	D.O.N. & STAFF DEVELOPMENT OFFICE	1997	1,236	82	15	82		536	6
7	WALLPAPER-ROOM 308	1997	1,440		5			1,440	7
8	DRAIN/SEWER WORK	1997	389	26	15	26		166	8
9	REMODEL WORK IN ROOM 309	1997	1,464	98	15	98		602	9
10	SIDERAIL 1/2 DELUXE	1997	958	64	15	64		394	10
11	SIDERAILS	1997	556	37	15	37		226	11
12	DRYWALL-NURSE STATION	1997	625		5			625	12
13	REHAB WALL WORK	1997	414		5			414	13
14	REROOFING	1997	64,129	3,206	20	3,206		19,773	14
15	BUILDING-REMODEL NURSES STATION	1998	18,510	740	25	740		4,442	15
16	CARPET-REMODEL NURSES STATION	1998	1,753		5			1,753	16
17	WALLCOVERING-REMODEL NURSES STATION	1998	1,794		5			1,794	17
18	FORM & POUR LAMP POST BASES	1998	800		5			800	18
19	SIDE RAILS	1998	812	54	15	54		325	19
20	KITCHEN DOOR	1998	1,242	83	15	83		476	20
21	CABINETRY & INSTALLATION	1998	3,799	190	20	190		1,092	21
22	ROOM 204 WORK	1998	2,532	253	10	253		1,456	22
23	VINYL COVERING-KICK PLATES	1998	1,367	137	10	137		786	23
24	HANDRAIL & INSTALLATION	1998	700	47	15	47		268	24
25	FIRE ALARM SYSTEM WORK	1998	1,090	109	10	109		618	25
26	BATHROOM FIXTURES	1998	412	41	10	41		230	26
27	ROOF FLASHING INSTALLATION	1998	753	75	10	75		420	27
28	KOROGUARD IN MED ROOM AND BATH	1998	1,008	101	10	101		563	28
29	CARPET	1998		46	5	46			29
30	GENERATOR	1998	47,534	2,377	20	2,377		13,666	30
31	BOILER TANK	1998	3,803	380	10	380		2,092	31
32	DOOR FRAME GUARDS	1998	593	40	15	40		217	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,473,353	$ 58,045		$ 58,045	$ 0	$ 1,038,858	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,473,353	$ 58,045		$ 58,045	$ 0	$ 1,038,858	1
2	BUILDING CONTINUED								2
3	WATER HEATER	1998	1,339	134	10	134		725	3
4	FLOORCOVERING CEILING TILE	1998	1,398	186	5	186		1,398	4
5	RESIDENT ROOM WORK	1998	996	50	5	50		996	5
6	CEILING TILE	1998	20,525	1,027	20	1,027		5,473	6
7	2000 PROJECT	1998	6,817	341	20	341		1,790	7
8	BATHROOM WORK	1998	2,121	212	10	212		1,113	8
9	AIR CONDITIONING	1998	24,279	1,624	15	1,624		8,175	9
10	HVAC SYSTEMS	1998	4,284	287	15	287		1,443	10
11	ALUMINUM ENTRANCE/AMBULANCE	1999	1,726	115	15	115		566	11
12	ROOF WORK	1999	2,800	280	10	280		1,283	12
13	HOUSE AND PROPERTY	1999	86,726	2,169	40	2,169		9,215	13
14	WOOD SIGN	1999	327	33	10	33		144	14
15	HVAC SYSTEMS	1999	2,350	235	10	235		1,077	15
16	PLUMBING-BATHROOM REMODEL	1999	4,739	237	20	237		1,106	16
17	BUILDING-REMODEL RESIDENT ROOM	1999	6,265	251	25	251		1,045	17
18	DRAPES-REMODEL RESIDENT ROOM	1999	279	56	5	56		233	18
19	ELECTRIC-REMODEL RESIDENT ROOM	1999	197	10	20	10		41	19
20	PAINT/REMODEL RESIDENT ROOM	1999	2,697	539	5	539		2,247	20
21	THERMOSTATS FOR APTS	2000	1,412	94	15	94		353	21
22	FAUCETS	2000	1,159	58	20	58		208	22
23	OAK CABINETS FOR KITCHEN	2000	1,603	107	15	107		401	23
24	LAUNDRY REPAIR	2000	533	107	5	107		399	24
25	BUILDING-RENTAL PROP IMPROVEMT	2000	19,696	788	25	788		2,823	25
26	CARPET-RENTAL PROP INPROVE	2000	60	12	5	12		43	26
27	GENERATOR REPAIR	2000	2,258	226	10	226		715	27
28	WATER SOFTENER	2000	541	54	10	54		167	28
29	MAINTENANCE GARAGE	2001	79,709	5,314	15	5,314		15,056	29
30	BLDG-REDECORATE 300 WING COORD	2001	8,062	322	25	322		806	30
31	CARPET-REDECORATE 300 WING	2001	1,986	397	5	397		993	31
32	FIRE ALARM CONTROL PANEL	2001	413	41	10	41		97	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,760,650	$ 73,351		$ 73,351	$ 0	$ 1,098,989	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,760,650	$ 73,351		$ 73,351	$ 0	$ 1,098,989	1
2	BUILDING CONTINUED								2
3	WORK ON HEAT UNITS	2001	3,856	386	10	386		804	3
4	FURNACE	2001	508	51	10	51		102	4
5	LAMINATE CABINETS-ACT.ROOM	2002	2,779	185	15	185		340	5
6	PHONE CABLE WIRING TO ROOMS	2002	700	70	10	70		117	6
7	AIR CONDITIONERS-BUILDING A	2002	6,175	617	10	617		1,132	7
8	BUILDING -REMODEL RESIDENT RMS	2002	32,873	1,315	25	1,315		2,192	8
9	CAULKING-REMODEL RESIDENT RMS	2002	193	19	10	19		32	9
10	CERAMIC TILE-REMDL RESIDENT RM	2002	181	9	20	9		15	10
11	CORNER GUARD-REMDL RESIDENT RM	2002	90	9	10	9		15	11
12	DRAPES-REMDL RES RM	2002	1,152	230	5	230		384	12
13	DRAPERY RODS-REMDL RES RM	2002	174	17	10	17		29	13
14	WALLPAPER-REMDL RES RM	2002	1,809	362	5	362		603	14
15	BLINDS-REMDL RESIDENT RM	2002	533	107	5	107		178	15
16	CAPET-THERAPY	2002	622	124	5	124		145	16
17	BUILDING-REDECORATE 100/200	2002	11,911	476	35	476		635	17
18	CARPET-REDECORATE 100/200	2002	5,069	1,014	5	1,014		1,352	18
19	CORNER GUARDS-REDEC 100/200	2002	170	17	10	17		23	19
20	DOORS-REDECORATE 100/200	2002	199	13	15	13		18	20
21	WALLPAPER-REDECORATE 100/200	2002	1,905	381	5	381		508	21
22	HOUSE @ CONGRESS ST	2002	86,553	3,462	25	3,462		3,751	22
23	SOLID CORE DOORS/SNF	2003	1,656	92	15	92		92	23
24	HOUSE @ 725 S CONGRESS	2003	86,773	2,025	25	2,025		2,025	24
25	LIGHTING FIXTURES	2003	6,755	225	10	225		225	25
26	HOUSE REMODEL	2003	8,234	137	25	137		137	26
27	BLDG-REMODEL	2003	5,173	86	25	86		86	27
28	WINDOWS	2003	2,494	28	15	28		28	28
29	DUAL SENSOR SMOKE ALARM	2003	1,276	11	10	11		11	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,030,463	$ 84,819		$ 84,819	$ 0	$ 1,113,968	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,030,463	$ 84,819		$ 84,819	$ 0	$ 1,113,968	1
2	LAND IMPROVEMENTS								2
3	DRIVES-GRADING-WALKS	1971	9,171		15			9,171	3
4	BLACKTOP	1973	5,865		15			5,865	4
5	PAVING	1974	3,499		15			3,499	5
6	IMPROVE WEST SIDE OF PARKING	1975	1,018		15			1,018	6
7	DIRT-EE SNODGRASS	1975	83		15			83	7
8	RESURFACE PARKING LOT	1978	3,817		15			3,817	8
9	SIDEWALK AROUND CENTER-DRAIN	1981	3,842		20			3,796	9
10	SOD AROUND BLDG	1981	1,450		10			1,450	10
11	PAVING-ASPHALT	1985	6,089		15			6,089	11
12	PARKING LOT CHESTNUT STREET	1988	62,030	3,791	15	3,791		62,030	12
13	DEMOLITION OF HOUSES	1990	2,985		10			2,985	13
14	LANDSCAPE	1990	69		10			69	14
15	GAZEBO	1991	11,223	561	20	561		6,874	15
16	ISABEL BLOOM FOR MEMORIAL	1992	300	20	15	20		230	16
17	ILLUMINATED SIGN BOX AND COVE	1992	5,288	441	12	441		4,994	17
18	TO LAY BRICKS FOR NEW SIGN	1992	383	32	12	32		359	18
19	LANDSCAPING MATERIAL	1992	2,764		10			2,764	19
20	GAZEBO	1995	9,618	641	15	641		5,290	20
21	FENCE	1995	6,242	416	15	416		3,433	21
22	BURY ELECTRIC LINE	1996	3,347	335	10	335		2,650	22
23	SITE IMPROVEMENTS-DUPLEXES	1996	50,912	5,091	10	5,091		37,760	23
24	GAZEBO	1997	2,850	143	20	143		950	24
25	WALK	1997	2,500	167	15	167		1,111	25
26	ENTRANCE AREA LANDSCAPING	1997	2,450	245	10	245		1,572	26
27	SPRINKLER SYSTEM	1997	726	48	15	48		295	27
28	PARKING LOT CHESTNUT STREET	1997	2,265	113	20	113		708	28
29	COURTHOUSE RESEARCH FOR PREP	1998	515	52	10	52		305	29
30	PATIO	1998	1,313	131	10	131		712	30
31	SKYLIGHT & FLASHING WORK	1998	1,607	161	10	161		870	31
32	SEED	1990	803		10			803	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,235,487	$ 97,207		$ 97,207	$ 0	$ 1,285,520	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,235,487	$ 97,207		$ 97,207	$ 0	$ 1,285,520	1
2	LAND IMPROVEMENTS CONTINUED								2
3	SIDEWALK	1999	475	48	10	48		218	3
4	BLOCKS/RETENTION POND	2001	1,128	56	20	56		132	4
5	FENCING AROUND SCREEN	2002	1,520	152	10	152		215	5
6	PARKING LOT LAMP POSTS	2003	508	46	10	46		47	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,239,118	$ 97,509		$ 97,509	$ 0	$ 1,286,132	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 585,410	$ 52,456	$ 52,456	$		$ 429,812	71
72	Current Year Purchases	35,145	2,767	2,767			2,767	72
73	Fully Depreciated Assets	208,060					208,060	73
74								74
75	TOTALS	$ 828,615	$ 55,223	$ 55,223	$		$ 640,639	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT CARE	TRUCK	1994	$ 3,000	$	$	$	2	$ 3,000	76
77		REBUILDING TRUCK	1996	3,596				4	3,596	77
78		19 PASSENGER VAN 1998	1998	46,953	8,026	8,026		3	44,946	78
79		WHEELCHAIR BELTS FOR VA	2003	795	83	83		4	83	79
80	TOTALS			$ 54,344	$ 8,109	$ 8,109	$		$ 51,625	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,148,077	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,841	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,841	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,978,396	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND	$ 160,693	$	$	86
87	BUILDING	2,963,741	89,563	431,321	87
88	LAND IMP	82,458	2,754	27,846	88
89	FFE	88,476	4,057	56,255	89
90					90
91	TOTALS	$ 3,295,368	$ 96,374	$ 515,422	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 31,051	92
93			93
94			94
95		$ 31,051	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,888 Description: NETWORK COMPUTER EQUIP LEASE , ONE TIME RENTALS
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 758	$	$ 758
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 758	$	$ 758
10	SUM OF line 9, col. 1 and 2 (e)	$ 758			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ NOT APPLICABLE		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 160,587	$	1
2	Cash-Patient Deposits	4,492		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	466,448		3
4	Supply Inventory (priced at)	11,710		4
5	Short-Term Investments	1,781,733		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	786		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,425,756	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	4,994,204		14
15	Leasehold Improvements, at Historical Cost	305,299		15
16	Equipment, at Historical Cost	971,436		16
17	Accumulated Depreciation (book methods)	(2,572,042)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	40,238		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ASSET MANAGEMENT, CIP	123,411		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,023,239	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,448,995	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,779	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	252,997		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,421		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,701		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	GROUP INS W/H GARNISHMENTS	(1,813)		36
37	SECURITY	24,373		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 555,458	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	REFD-DPLX ENT FEE,NON REFD-DPLX ENT FEE	1,720,427		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,720,427	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,275,885	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,173,110	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,448,995	$	48

***(See instructions.)**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,022,683	1
2	Restatements (describe):		2
3	CONGREGATE	25,121	3
4	APARTMENTS	37,646	4
5	DUPLEXES	81,482	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,166,932	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	88,790	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) DNR RST OPER GFT-GRANT-CASH	13,079	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 101,869	17
	B. Transfers (Itemize):		
18	CASH ASSET ASSESS, CO/FOUNDATION FUND TRNSF	(95,698)	18
19	ROUNDING	7	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (95,691)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,173,110	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,377,181	1
2	Discounts and Allowances for all Levels	(476,292)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,900,889	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	5,369	5
6	Therapy	107,877	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 113,246	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	867	12
13	Barber and Beauty Care	1,467	13
14	Non-Patient Meals	1,043	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	14,645	16
17	Sale of Drugs	31,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,465	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 62,073	23
	D. Non-Operating Revenue		
24	Contributions	26,267	24
25	Interest and Other Investment Income***	127,591	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 153,858	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nsg & Med Supplies	16,104	28
28a	Schd Attached	(7,045)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,239,125	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	728,746	31
32	Health Care	1,429,830	32
33	General Administration	776,451	33
	B. Capital Expense		
34	Ownership	175,265	34
	C. Ancillary Expense		
35	Special Cost Centers	40,043	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,150,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	88,790	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 88,790	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,898	2,139	$ 51,178	$ 23.93	1
2	Assistant Director of Nursing	207	209	4,226	20.22	2
3	Registered Nurses	8,430	9,299	168,938	18.17	3
4	Licensed Practical Nurses	8,642	9,465	139,840	14.77	4
5	Nurse Aides & Orderlies	63,670	70,884	743,991	10.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	233	236	4,949	20.97	7
8	Rehab/Therapy Aides	542	542	7,152	13.20	8
9	Activity Director	1,946	2,177	27,286	12.53	9
10	Activity Assistants	3,657	4,221	33,110	7.84	10
11	Social Service Workers	2,474	2,740	39,948	14.58	11
12	Dietician					12
13	Food Service Supervisor	1,964	1,949	25,851	13.26	13
14	Head Cook	5,466	5,458	53,857	9.87	14
15	Cook Helpers/Assistants	10,629	12,479	94,233	7.55	15
16	Dishwashers					16
17	Maintenance Workers	5,972	7,707	77,965	10.12	17
18	Housekeepers	8,476	9,322	81,081	8.70	18
19	Laundry	6,096	7,131	65,665	9.21	19
20	Administrator	1,289	1,577	41,361	26.23	20
21	Assistant Administrator					21
22	Other Administrative	2,124	2,232	26,438	11.84	22
23	Office Manager	1,297	1,619	21,164	13.07	23
24	Clerical	1,760	2,116	23,419	11.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,700	2,856	44,450	15.56	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing & Res I	995	1,060	14,217	13.41	33
34	TOTAL (lines 1 - 33)	140,467	157,418	$ 1,790,319 *	$ 11.37	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	138	$ 5,798	Ln 1, Col 3	35
36	Medical Director	12	1,200	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,375	Ln 10, Col 3	39
40	Physical Therapy Consultant	383	20,485	Ln 10a, Col3	40
41	Occupational Therapy Consultant	320	15,836	Ln 10a, Col3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	37	2,429	Ln 10a, Col3	43
44	Activity Consultant	40	2,637	Ln 11, Col 3	44
45	Social Service Consultant	20	1,247	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	950	$ 53,007		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Olson	Administrator	100	$ 41,361
Vacation Accural			552
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 41,913

B. Administrative - Other

Description	Amount
Adm/Acctg Serv	$ 122,267
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 122,267

C. Professional Services

Vendor/Payee	Type	Amount
64541 Good Samaritan	MDCD-CR Prep	$ 800
64540 BDO Seodam	MDCDR-CR Prep	700
64360 Berens & Tate	Prof Svc	2,987
58000 Contract Serv -Admin	JCAHO & Doc Distruction	547
Nash, Nash, & Bean	64363 Professional Services	446
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,480

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,766
Unemployment Compensation Insurance	51
FICA Taxes	139,834
Employee Health Insurance	135,332
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts Payments	450
Staff Pension	36,201
Newsletter - Admin	1,789
Employee Physicals	64
Admin/Consultant Savings	2,051
FICA - Res Dev	(2,210)
TOTAL (agree to Schedule V, line 22, col.8)	$ 361,328

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Publications - Reimb	877
Public Relations - Reimb	6,785
Dues - Reimb	6,852
Advert/Promo - Admin	2,498
Advertising & Promo - Res Dev	8,633
Less: Dues	(6,852)
Less: Public Relations Expense	(6,785)
Non-allowable advertising	(11,131)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 877

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,585
In-State Travel	509
Seminar Expense	1,146
Less: Res Dev Travel	(673)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,567

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT & LABOR	1/97	$ 1,539	5	$ 308	$ 308	$ 25	$	$	$	$	$	$
2	PAINT	3/97	23	5	4	4	4						
3	PAINT	4/97	37	5	7	7	4						
4	PAINT	5/97	45	5	9	9	4						
5	PAINT	1/98	283	5	57	57	55						
6	WALLPAPER	3/98	362	5	72	72	72	20					
7	PAINT	4/98	343	5	69	69	69	22					
8	WALLPAPER/PAINT	5/98	723	5	145	145	145	60					
9	WALLPAPER/PAINT	6/98	38	5	15	15	15	11					
10	PAINT	7/98	65	5	13	13	13	6					
11	PAINT	8/98	361	5	72	72	72	43					
12	PAINT	10/98	75	5	15	15	15	11					
13	PAINT	12/98	864	5	173	173	173	158					
14	PAINT	2/99	1,800	5	360	360	360	360	60				
15	PAINT	3/99	4,032	5	806	806	806	806	203				
16	PAINT	4/99	97	5	19	19	19	19	8				
17	PAINT PT ROOM	7/99	44	5	9	9	9	9	4				
18	PAINT & LABOR	8/99	10	5	2	2	2	2	1				
19	PAINT	9/99	130	5	26	26	26	26	20				
20	TOTALS		$ 10,871		$ 2,181	$ 2,181	$ 1,888	$ 1,553	$ 296	$	$	$	$

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT	11/99	34	5	1	7	7	7	7	5	$	$	$
2	WALLPAPER	7/00	1,295	5		129	259	259	259	259	130		
3	WALLPAPER/PAINT	12/00	2,533	5		42	506	507	507	507	464		
4	PAINT	6/00	64	5		7	13	13	13	12	6		
5	PAINT	02/01	496	5			91	105	105	105	91		
6	PAINT	06/01	348	5			35	93	93	93	34		
7	PAINT	06/01	120	5			12	32	32	32	12		
8	PAINT	06/01	192	5			19	51	51	51	20		
9	PAINT	08/01	70	5			4	21	21	21	4		
10	PAINT	08/01	68	5			4	20	20	20	4		
11	PAINT	08/01	30	5			1	9	9	9	2		
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,250		$ 1	$ 185	$ 951	$ 1,117	$ 1,117	$ 1,114	$ 767	$	$

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 11,314 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 39,501
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? YES Indicate the amount. $ 1,043

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 25%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HENRY SCHOLTEN & COMPANY The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.